Name: Date of Birth:

What brings you to counseling at this time? Is there something specific, such as a particular event? Be as detailed as you can.

What are your goals for counseling?

Have you seen a mental health professional before? Yes / No
Who have you seen in the past?

Specify all medications and supplements you are presently taking and for what reason.
If taking prescription medication, who is your prescribing MD? Please include type of doctor (i.e. psychiatrist, primary care, cardiologist, etc.), name and phone number for each medication.

Who is your primary care physician? Please include type of MD, name and phone number.

Do you drink alcohol? Yes / No

Do you use recreational drugs? Yes / No

Do you consider yourself religious and/or spiritual? Yes / No

Do you attend religious services, if so, where?

Do you have suicidal thoughts? Yes/ No
*If your thoughts include a plan, please consider calling 911 for help to keep you safe

Have you ever attempted suicide? Yes / No

Do you have thoughts or urges to harm others? Yes / No
*If your thoughts include a plan to harm someone, please consider calling 911 for help to keep yourself and others safe

Have you ever been hospitalized for a psychiatric issue? Yes / No

Is there a history of mental illness in your family? Yes / No

Have you experienced any physical or mental trauma? Yes / No

If you are in a relationship, please describe the nature of the relationship and months or years together.

Describe your current living situation. Do you live alone, with others. With family, etc...

Have you ever had any difficulties with learning, i.e. dyslexia, ADHD, etc. Were you diagnosed? When were you last evaluated for difficulties?

What is your highest level of completed education? Highest grade/degree and type of degree.

What is your current occupation? What do you do? How long have you been doing it?

Please circle any of the following you have experienced in the past six months:

Increased appetite / Decreased appetite
Trouble concentrating
Difficulty sleeping / Excessive sleep
Low motivation / Fatigue/low energy
Isolation from others
Low self-esteem
Depressed mood
Tearful or crying spells
Anxiety
Fear
Hopelessness
Panic

Please circle any of the following that apply (within the past two weeks):

Headache
High blood pressure
Gastritis or esophagitis (upset stomach and/or acid reflux/ heartburn)
Hormone-related problems
Head injury
Angina or chest pain
Irritable bowel
Chronic pain
Loss of consciousness

Heart attack
Bone or joint problems
Seizures
Kidney-related issues
Chronic fatigue
Dizziness
Faintness
Heart valve problems
Urinary tract problems
Fibromyalgia
Numbness & tingling
Shortness of breath
Diabetes
Hepatitis
Asthma
Arthritis
Thyroid issues
HIV/AIDS
Cancer
Other

What else would you like me to know?